Inschrijfformulier V&V Huisartsen

Mw. N.J. Pes-Veenstra, mw. H.M.M. Vos en dhr. J.P. van der Weert, huisartsen
Apeldoornselaan 79 – 2573 LD – Den Haag – Tel: 070-3603322

Family name:_____M/F
Initials:_____ First name:_____
Date of birth:_____Place of birth:_____
Address:_____
Zip code:_____Place of residence:_____
Phone number:_____
E-mail:_____
Profession:_____
Health insurance company:_____
Policy number:_____ Social security number (BSN):_____
Previous house doctor:_____Place of residence:_____

Family name:_____M/F
Initials:_____ First name:_____
Date of birth:_____Place of birth:_____
Address:_____
Zip code:_____Place of residence:_____
Phone number:_____
E-mail:_____
Profession:_____
Health insurance company:_____
Policy number:_____ Social security number (BSN):_____
Previous general practitioner:_____Place of residence:_____

Family name	First name	Initials	M/F	Date of birth	Health insurance company	Policy number	Social security number
			M/F				
			M/F				
			M/F				
			M/F				

Do you want us to register your medical record at the National Exchange Point (LSP) in order to share your medical data electronically with the pharmacy and de general practitioner that is on call during the weekend (ask the assistent for the brochure)? **Yes/No**

I want to register at V&V Huisartsen and give my permission to forward my electronical medical record from my previous general practitioner to V&V Huisartsen (I will take care for unsubscribing from my previous general practitioner and I will retrieve my paper medical record myself).

Place:_____ Signature:
Date: _____

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Name: _____ **Date of birth:**_____

Did you ever suffer from:

- Diabetes
- High blood pressure
- Myocardial infarction
- Asthma
- COPD/emphysema
- Thyroid gland
- Depression
- Anxiety disorder
- Gastro-intestinal or liverdisease, such as:_____
- Reumathoïde arthritis
- Cancer, namely_____
- Other: _____

Do you take medication? If yes, which?

_____
_____
_____
_____
_____
_____
_____
_____

Are you being treated by a medical specialist? If yes, fill in the name of the specialism, name and hospital:

1._____
2._____
3._____

Do you have any allergies?

- No
- Medications namely:_____
- Iodine and/or wound dressings
- Other:_____

Did you recieve an influenza vaccination last year?

- No
- Yes, because of:_____

Have you ever been hospitalized for an operation or an accident? If yes, please fill in when and what:

1._____
2._____
3._____

Do you currently smoke?

- No
- Not anymore, I quit ____ year ago
- Yes, _____ sigarets a day

Do you drink alcoholic beverages?

- No
- Yes, _____ glasses a day/week

Are there any diseases or medical problems that run in your family (parents, siblings, children)?

- No
- High blood pressure
- Cardiovascular disease younger that 65 years old
- Diabetes
- High cholesterol
- Cancer, namely_____

For women only:

Did you suffer from:

- Gestational diabetes
- High blood pressure during pregnancy
- (Pre)eclamsia
- Menopausal flushes

Are you pregnant?

- No
- Yes, last period:_____
- Due date:_____
- Midwife:_____